PATIENT INFORMATION

Patient Name: _____ (Last) , _____ (First) ___ (MI) _____ (Preferred) Date: _____

Date of Birth: ____ (Month) - ____ (Date) - ____ (Year) Social Security #: _____-_____-_____ Gender: M F

Address: _____ Email: _____

_____ (City) (ST) (Zip) Marital Status: M S D W

Phone (Cell) _____ (Home) _____ (Work) _____ ext: _____

We notify patients of upcoming appointments via text messages and/or email. Which do you prefer?

Text _____ Email _____ Both _____ Neither, please call _____

RESPONSIBLE PARTY/SUBSCRIBER

_____ Patient is responsible for payment or is the Subscriber for the dental insurance (Skip this section)

Name: _____ (Last) , _____ (First) ___ (MI) Relationship to Patient: _____

Date of Birth: ____ (Month) - ____ (Date) - ____ (Year) Social Security #: _____-_____-_____ Gender: M F

Address: _____ Email: _____

_____ (City) (ST) (Zip) Marital Status: M S D W

Phone (Cell) _____ (Home) _____ (Work) _____ ext: _____

DENTAL INSURANCE INFORMATION

_____ Patient does NOT have dental insurance (Skip this section.)

_____Copy of your dental insurance card provided. (Skip this section.)

Insurance Company's Name: _____ Group Number: _____

Insurance Company's Address: _____ (City) (ST) (Zip)

Insurance Company's Phone Number: _____ Employer: _____

Subscriber's ID Number: _____ (It may be the SSN of the subscriber.)